No. 2
1-10-39
-17-39
X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 11 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26374

Registration District No. 836 — Primary Registration District No. 45-07 — Registrar's No. 41

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Bernie
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community W. M.

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Stoddard
(c) City or town Bernie Mo
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME W. R. V. Grimes
3. (b) If veteran, name war —
3. (c) Social Security No. X

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Laura Grimes
6. (c) Age of husband or wife if alive 71 years
7. Birth date of deceased April (Month) 4 (Day) 1853 (Year)

8. AGE: Years 88 | Months 3 | Days 10 | If less than one day ___ hr. ___ min.

9. Birthplace Clay Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name Bige Grimes
13. Birthplace unknown (City, town, or county) Tenn (State or foreign country)
MOTHER 14. Maiden name Murphree
15. Birthplace unknown (City, town, or county) SC (State or foreign country)
16. (a) Informant Carl Grimes
(b) Address Bernie Mo.
17. (a) B (Burial, cremation, or removal) (b) Date thereof July 16, 1941 (Month) (Day) (Year)
(c) Place: burial or cremation Bernie Mo
18. (a) Signature of funeral director Floyd Russell
(b) Address Piggott, Ark
19. (a) July 28 1941 (Date received local registrar) (b) Lelora Hopkins (Registrar's signature)
895

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14
year 1941 hour 8 minute ___ M.
21. I hereby certify that I attended the deceased from 6-1-41
6-1-, 1941, to 7-14-, 1941,
that I last saw him alive on 7-12-, 1941,
and that death occurred on the date and hour stated above. 8:30 P.M.

Immediate cause of death Dysentery — Duration 7 months
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Dewey Pigg (M. D. or other) D
Address Bernie Mo Date signed 7-27-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 841-1033
Date Filed 8-9-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

. No. 2B
—8-21-41
PI X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26374

Registration District No. 836 Primary Registration District No. 4507 Registrar's No. 41

1. PLACE OF DEATH:
(a) County S Stoddard
(b) City or town Bernie (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Stoddard
(c) City or town Bernie (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William Billy Grimes

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from ..., 19...;
that I last saw h... alive on ..., 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (c) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY